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OF THE NATIONAL TUBERCULOSIS ASSOCIATION

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The Unit of Care*

From the early days of the tuberculosis movement to the present time the suggestion has been made at intervals that the care of the tuberculous should be undertaken by the Federal Government. A moment's reflection will show, however, that quite aside from the financial considerations involved, the control of tuberculosis, of which treatment and hospitalization are the most costly part, is a state and a local problem. If tuberculosis control is to be viewed as part of the public health, it cannot under the Constitution of the United States be considered as a federal problem; it must be included in those powers and responsibilities retained by the several states and by them in turn delegated to local communities.

That this has been the attitude of the 48 states, is amply demonstrated in the figures showing the classification of tuberculosis facilities by units of government. Of the 1240 tuberculosis hospitals, sanatoria and departments listed in its survey by the American Medical Association, 807 were publicly owned institutions. Of this number 638 were city, county or state-owned and only 169 federal agencies.

Nearly one-half (293) of the publicly-owned tuberculosis institutions fall in the classification of sanatoria as contrasted with departments of general and other hospitals. County sanatoria and city-county sanatoria constitute 188 of this latter group of 293, state sanatoria 65, city 22 and federal 18. This situation reflects to a large extent the steady agitation since 1910 for the county as the generally best unit for institutional care of the tuberculous. Experience of most of the 48 states would seem to indicate that the county is better than the state as a unit, because it brings the sanatorium closer to the patient whom it is desired to help. For the most part the county is preferred to the city as a unit, for the reason that the rural territory gets better protection in this way.

* This is the third in a series of comments based upon the American Medical Association's Survey of Tuberculosis Hospitals and Sanatoria in the United States.

Of the 18 federal sanatoria for tuberculosis, six are for tuberculous veterans, eleven for Indians, and one (Ft. Stanton) for government personnel not in the Army or Navy. Of the 151 tuberculosis departments operated by the federal government, 59 are in the Veterans Administration, 41 in the Indian Service, 25 in the United States Public Health Service, 13 in the Army, 10 in the Navy and three in other services. The total capacity of all these institutions is only 10,940 beds, about 11 per cent of the total beds for tuberculosis in the United States, again showing how American experience has tended to place the responsibility for tuberculosis control on the states and localities.

"Weasel Words"

A prominent man once said of another that his expressions were "weasel words," meaning thereby that they might be interpreted in different ways. There are several words in the common vocabulary of tuberculosis workers and more particularly in the vocabulary of newspaper men, that are "weasel words" or possibly one might better say, "taboo words."

One of them is our old friend "tubercular" as a substitute for "tuberculous." The adjective "tubercular" (it can never be used correctly as a noun), means a nodular formation in the tissues of the body that is produced by something other than the tubercle bacillus. Any process caused by the tubercle bacillus is a "tuberculous," not a "tubercular" process.

Recently a newspaper in California wrote about a "tubercular test in a preventive campaign." Certainly the use of the term "tubercular" to describe a tuberculin test is about as wrong as wrong can be.

Another of these tabooed words is "preventative." Once in a while there is use for the noun "preventative" though usually the shorter word "preventive" is quite as good if not better. There is no use for the word "preventative" as an adjective; it is distinctly out of place used thus.

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TUBERCULOSIS AND CLIMATE . . .

The Need for Scientific Study*

by JEAN DOWNES

THE relation between climate and tuberculosis has been studied in various ways during the past three decades, but in only a few instances has there been an attempt to set up scientifically controlled experiments.

Climate may be defined as the temperature and meteorological conditions of a country, or as the effects of the sun, atmosphere and earth upon living objects at a given place on the earth's surface. Radiant energy is one of the elements of climate as are also humidity, rain, snow, wind, density, and temperature, all of which determine, with other factors, what the atmosphere shall be. Some of these various factors which contribute to climate have been studied in relation to tuberculosis. For example, Miner investigated the influence of winter climate on pulmonary tuberculosis in the United States.[1] He showed the tuberculosis death rates for the rural white population in each of the registration states for the year 1920 grouped according to the January mean temperature. The death rates were found to be higher in those states with a mean January temperature between 30° and 40° F. than in colder or warmer regions. There was no evidence to support the view that severe winter climates, or poor ventilation resulting from them, are important factors in the etiology of tuberculosis.

Baetjer and Lange studied the effect of high humidity and moderately high temperature on the susceptibility and resistance to tuberculosis by means of a carefully controlled laboratory experiment.[2] They found that a temperature of 80° F. and 79 per cent relative humidity, when compared with 69° F. and 45 per cent relative humidity, did not alter the susceptibility and resistance of guinea pigs to infection with a virulent strain of tubercle bacillus.

Recently a statistical study of climate in relation to pulmonary tuberculosis in the United States has appeared.[3] All of the 46 states in the Registration Area were included with the exception of New Mexico, Arizona, California and Nevada. These particular states were excluded because their death rates from tuberculosis were not considered comparable with the remaining 42 states. The study was made by the method of correlating the average mortality for three years (1928-1930) from pulmonary tuberculosis among white persons in each of the 42 states

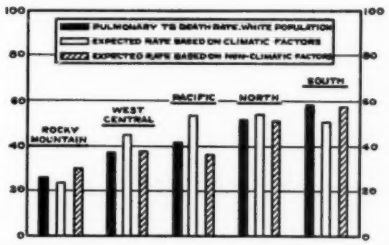

FIGURE 1. *Tuberculosis death rate (white) and expected rates based on climatic and non-climatic factors, by regions. (Reproduced from Cowles, Alfred, 3rd and Chapman, Edward N.: A Statistical Study of Climate in Relation to Pulmonary Tuberculosis. "Journal of the American Statistical Association," September, 1935, xxx.)*

with indices of climate and with indices of certain environmental or social conditions in each of the states. The authors draw the following general conclusion: "Insofar as the states of the United States are concerned, high standards of education and minimizing the risk of infection from Negroes, combined with life in a sunny, dry, and high altitude climate, would seem to be far more important than other elements, such as large per capita income or low population density, in reducing to a minimum the white death rate from pulmonary tuberculosis."

It is a relatively simple matter to obtain fairly specific indices of climatic conditions such as hours of sunshine, precipitation, relative humidity, etc., which expressed as averages may be representative for each state. However, data

* From the Milbank Memorial Fund, New York, N. Y.

[1] Miner, John Rice: The Influence of Winter Climate on Pulmonary Tuberculosis in the United States. *The American Review of Tuberculosis*, April, 1926, xiii, No. 4.

[2] Baetjer, Anna M. and Lange, Linda B.: The Effect of High Humidity and Moderately High Temperature on the Susceptibility and Resistance to Tuberculosis in Guinea Pigs. *The American Journal of Hygiene*, November, 1928, viii, No. 6.

[3] Cowles, Alfred, 3rd and Chapman, Edward N.: A Statistical Study of Climate in Relation to Pulmonary Tuberculosis. *Journal of the American Statistical Association*, September, 1935, xxx.

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concerning social conditions, which may be closely related to the occurrence of tuberculosis in the various states, are not easily available. Those indices of social environment which were used in the study lose much of their significance when based on an average for areas as large as states, since the variation within a state may be very great.

Population density per square mile, for example, is a meaningless measure of potential risk of infection due to crowding when applied to an area as large as that of most of the states. Colorado has a population density of only 10 persons per square mile and Utah 6 persons per square mile, but slightly more than 50 per cent of the total population of these states lives in cities of 10,000 or more persons.

Some indices when applied to 46 states do not reflect the same social and economic environment, though practically identical values be observed in two states. Connecticut and Alabama have almost identical proportions of illiterate whites in their populations, namely, 4.51 and 4.87 per cent. The same is true for New York and Georgia, with 3.72 and 3.35 per cent, respectively. Yet these states differ widely in their social environment.

The per capita expenditure for public elementary and secondary schools in the various states does not answer questions specifically related to the tuberculosis death rate. Rather, it probably reflects the extent to which community life is supported by community funds. Of no little importance in the development of community life also has been the organization of health programs with expenditure of funds for sanitation, preventive medicine and health education of the individual and community as well as provision for control of specific diseases such as tuberculosis.

But if we accept the indices used as having some significance even though they lack precision, care and judgment must be exercised in the use and interpretation of correlation, especially in attempting to gauge the effect of conditions as complex as those that constitute social environment. A careful scrutiny of the distributions of the various items related in this study throws some doubt upon the validity of the conclusions drawn. For example, considerable space is given to the discussion of the relationship of the per cent of population colored to the pulmonary tuberculosis death rates among the white populations of the various states. For nine of the southern states there was an inverse relationship between the tuberculosis death rates and the per cent colored. For the remaining 33 states the relationship was positive. After removing the "hill billy" influence by the exclusion of Arkansas from the former and Kentucky and Tennessee from the latter group of states the relationship remained the same. The authors draw the conclusion that "the per cent of population colored appears to have a considerable direct relationship to the tuberculosis death rate for the white population in the case of 33 states with less than 19 per cent Negroes." This seems like an exaggeration when it is noted that the relationship is determined mainly by the influence of three states, Oklahoma, Delaware and Maryland. In the remaining 28 states, excluding Kentucky and Tennessee, less than 7 per cent of the population is colored and the simple correlation coefficient indicates only a moderate degree of association.[4]

A careful examination of the chart which shows the pulmonary tuberculosis death rate in the five geographical divisions of the United States compared with the expected rate based on climatic factors and the expected rate based on non-climatic factors does not bear out the interpretation placed upon it in the text of the article. In three of the five geographic regions the expected rate based on non-climatic factors more nearly approximates the observed rate than does the rate based on climatic factors. In the Rocky Mountain states and the North the expected rate based on non-climatic factors is just about as close to the observed rate as that based on climatic factors. This would seem to indicate from the data of the study that non-climatic factors are more important than climatic factors in determining the death rate in all parts of the United States except the Rocky Mountain region and the North and in those regions, climatic and non-climatic factors are of approximately equal importance.

One cannot escape the conclusion that some of the indices used in the study are inadequate and that there has been "over-interpretation" of the data. The study does not offer conclusive or clear evidence of the relation of climate to tuberculosis but rather indicates the need for a more refined investigation.

[4] Baker has called attention to the effect of extreme values on the coefficient of correlation when samples of about 50 observations are dealt with. Baker, George A.: The Significance of the Product-Moment Coefficient of Correlation with Special Reference to the Character of Marginal Distributions. *Journal of American Statistical Association*, December, 1930.

THE CHANGING PICTURE

Tuberculosis Nursing Plays an Important Part Today

by VIOLET H. HODGSON, R.N.*

HERETOFORE, nursing in tuberculosis has referred specifically to the preventive program of the public health nurse and to the service of the institutional nurse in the sanatorium. In rare instances were both types of nursing thought of as parts of one service, nor was there any apparent plan followed by which close integration would be effected. Unfortunately, this situation is still prevalent. That such a state of affairs is unsound would seem apparent, if for no other reason than the mutual interest which each has in the welfare of the patient who is at one time a part of the community program and at another a recipient of hospital care. At all times, however, he continues to be an *individual* with varying needs in relation to his disease. This social unity of the individual should bring about greater interrelatedness of the two types of nursing service.

Of further significance to all nursing in tuberculosis is the increasing emphasis placed on prevention. If the prevention of tuberculosis is to be community-wide in scope, it must be a responsibility shared by the institutional, private duty, and public health nurse. The general trend in all nursing is in this direction. In a number of schools, the students' introduction to nursing is through contact with a well person to whom instruction is given in the maintenance of health and the prevention of illness. How different from the method of former years (used even in the majority of training schools to-day) where every one with whom the student came in contact was a sick person. This trend alone clearly marks the responsibility of the graduate in the preventive field. All nurses, whether serving in the homes of the well-to-do, of the less fortunate economically, or in the hospital, alike are confronted with an opportunity in sharing health knowledge and the means of controlling the spread of tuberculosis.

DOWNWARD TREND OF DEATH RATE

What do we find in the tuberculosis picture that further influences the part played by the nurse? Of most widespread significance is the general downward trend of the death rate. From that of 160 per 100,000 of the population twenty-five years ago, the rate for the country as a whole is now 57. A number of states can point with pride to a rate considerably lower than this all-time minimum, and this in spite of the economic hardships of the past five years. Whether or not these gains can be held remains to be seen. Whatever the death curve of the future may reveal, certain it is that the control forces which have been at work must have been sound to attain such a picture of accomplishment during a period when the prevailing factors reflected in body resistance in many respects have been adverse to tuberculosis control.

In nursing, this has meant fewer cases needing bedside care in the home. On the other hand, the marked increase in the number of sanatorium beds for the same period from 20,000 to 87,000 has necessitated a proportionate increase in the need for institutional nursing.

The mortality curve has also shown more clearly the black spots. Tuberculosis still claims individuals at all ages, but it displays a marked partiality for infants and young adults from 16-35 years of age. It is no longer a wise expenditure of money and energy to carry on a non-discriminating program of control emphasis on all age groups. Instead, attention is being given to those falling within these particularly hazardous age periods. In other words, the program has become intensive rather than extensive. In nursing, this points directly to the prenatal, infant, and young adult services in the home, the high school, and in the place of work.

DIAGNOSIS

A second highly significant change in the tuberculosis field is that of diagnostic methods. The stethoscope still plays a prominent part but it has given way to tuberculin testing and X-ray which have shown a sensitivity to recognition of infection and the early stages of the disease. The tuberculin test has undergone a right about face in its potential usefulness. No longer is it an indication merely for prolonged observation

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of the infected individual but rather is it a clue to the search for the source of infection. The X-ray has brought hope to many an early case that might have gone on to a hopeless stage.

This change in diagnostic procedure has opened up a rich field for the nurse in epidemiology in which the unknown spreader of bacilli can be found and treatment offered that will mean safety to the family and community.

Treatment

Along with changes of diagnostic procedure have come changes in treatment. Rest still remains the keystone of curative methods. Instead of years of postural rest in bed, however, the period has been markedly shortened by the introduction of surgical procedures. Pneumothorax, phrenicectomy, thoracoplasty and other methods have changed the picture in sanatorium care. Similarly, they have offered a measure of security to the patient's job which the older method was helpless in safeguarding. What this has meant in saving of money to the community is difficult to estimate. In nursing, it has meant a change in teaching of the concept of rest from that of complete rest for the entire body to local rest of the diseased lung with limitation of exercise. In a sense, it has changed, to a large degree, medical into surgical nursing.

A further salutary change can doubtless be attributed to the progress made by the mental hygiene movement. The modern practitioner and sanatorium superintendent are just as much concerned with the mental attitude of the patient and family as they are with the pathology of the disease. No longer is the individual regarded as an interesting case, or otherwise, from the standpoint of physical findings alone. His needs as a social unit are receiving intelligent recognition as potential factors in the treatment of the disease process. His fears are allayed by a sympathetic explanation of his condition, and the nature of treatment indicated as described in terms intelligible to him. Sanatorium care is not thrust upon him in a "take it or leave it" attitude, dependent upon the beds or lack of beds available. The new regimen of living is explained in terms of his needs.

Neither is his family considered as a meddlesome complication to be tolerated as best one can, but now is a part of the patient picture and an invaluable aid to successful treatment when taken into the physician's confidence. Of equal significance is the opportunity afforded through the family for early case finding and prevention.

Nor are the community interests of the patient lost sight of. His job is regarded on a plane of importance equal to that of his health. The sacrifices of the family in the cessation of income are weighed and arrangements are made for supplementing the family budget simultaneously with those for the care of the patient.

Indeed, intelligent care of the tuberculous does not end here. To send a patient forth from the sanatorium handicapped in competing in an economic society is not the goal of a socially-minded institution. Rehabilitation under medical supervision is a logical development of a sanatorium which is fully cognizant of its opportunity in serving the patient, family, and taxpayer.

In such a far-reaching program comes the opportunity of interpreter and friend, beginning with the nurse whose privilege it is to care for the patient in the institution and extending to the public health nurse who continues the instruction and guidance in the home. Interpreters, they may be not only of the medical and rehabilitation program but of the fundamental principles of hygiene which will enable the patient and family to make adjustments that will bring a measure of physical safety to all. And with this physical adaptation, there must go a change of mental attitude in which physical and economic handicaps can be viewed with a measure of serenity and satisfaction. New ways of finding recreation will be suggested to result in greater emotional satisfactions than those heretofore experienced in an unplanned way of living. Introspection and self-pity must give way to larger interests and opportunities for service to others.

How Will the Nurse Adapt Herself?

The extent to which the nurse will function in such a changed program will depend upon herself. In the first place, her knowledge of the disease and modern methods of treatment should keep pace with the developments in the field of medicine. This can be done by reading and attendance at lectures and meetings. Her mind should be open as to methods and instruction based on those approved by the attending physician upon whom falls the responsibility for diagnosis and treatment.

Secondly, the nurse in the institution and in the community will strive to perfect her teaching methods so that increasing skill will be acquired in translating scientific knowledge into the language of all mental levels. The goal will be a well-informed patient and family imbued with a desire to put into practice the knowledge obtained through instruction in the

sanatorium and in the home, to the end that the family will be a responsible health unit in the community. In so doing, there may be a shift from one of our present yardsticks of measurement of field nursing service from that of attaining a prescribed standard of visits.

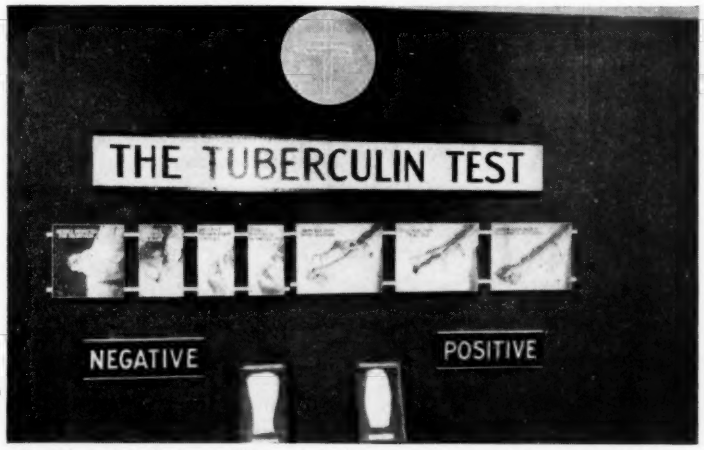
In the next place, the position of the nurse in the present day tuberculosis program will be determined to a large extent by the kind of person she is.

Nursing has recognized the defects in the basic preparation of the nurse and steps are being taken to make this preparation one of education as well as training in techniques and procedure. Science and skill are essential in the basic equipment for this field. But just as it is no longer considered adequate to minister to the patient's physical condition without thought for his mental and social needs, so, too, nursing recognizes the importance of the individual to whom education is to be given in nursing. "The light touch" so cherished by the patient, comes not alone from repetition of formalized techniques but rather from an understanding of the patient as a personality with a variety of interests, desires, and needs. To this end, scientific knowledge and manual dexterity must be combined with an understanding of people in a society in which a multiplicity of factors are at work shaping individual lives. Self-discipline in shaping her own life toward a goal of wider and richer horizons of thought in which there is less and less room for the trivial should bring a perspective to the commonplace activities of life in which judgment, understanding, and true sympathy will permeate the more strictly professional aspects of the nurse's service.

And finally, can we be certain that nursing has explored all potential fields of service in the community? The need, if any, for further expansion in the tuberculosis hospital field is not great. The same cannot be said for the general hospital. Whether or not it has set aside a number of beds for tuberculosis patients, the number of nurses who are graduated from training schools without experience in the tuberculosis out-patient service still constitutes the vast majority.

The work that is done among the early adult groups in high schools is far from widespread in scope, in spite of our knowledge that this age constitutes a part of the peak age incidence in the mortality rate. A beginning has been made in the colleges but much more must be done in this field. And when we come to the industrial group, the largest potential source of cases and the most important economically and socially, one thrills at the thought of the progress that could be made among them in bringing tuberculosis under control. If the facilities now at hand were made more generally available to this large group of citizens it would be benefited before obvious signs of the disease could manifest themselves.

In all these fields there is a place for the alert, well-informed nurse, who is aware of her opportunity, to play a large part in making tuberculosis a disease of minor significance in community life.



Central panel of the loan exhibit on the Tuberculin Test shown at the American Medical Association meeting in Kansas City. Doctors were much interested in the photograph showing how the test is made and in observing the lifelike models of positive and negative reactions. This exhibit will be effective for use with medical groups and if interested ask your state tuberculosis association about it.

NEGRO HEALTH WEEK IN ATLANTA

by MARY DICKINSON*

THE 1936 "Negro Health Week" in Atlanta, Georgia, stressed tuberculosis in a most practical way. The six Negro physicians on the medical staff of the Atlanta Tuberculosis Association and the two Purves Fellowship students who are seniors in the Atlanta School of Social Work, gave almost their full time to promoting the tuberculosis program.

Tuberculosis exhibits were set up in five centers throughout the city. A program of early diagnosis and the association's machinery was presented in every college, in the churches and before practically every audience addressed throughout the city. Every college devoted chapel exercises to a discussion of tuberculosis. This was a part of the essay writing contest promoted by state and National associations. The Booker T. Washington High School also centered its attention on tuberculosis. They had recently given tuberculin tests to over 500 boys and girls and they inaugurated health essays as a part of their Negro Health Week celebration. This writing of essays was required in all classes and from the groups of children participating will be selected those who may enter the essay contest promoted by the local and National associations.

The center of these interests in tuberculosis was the medical staff and clinics of the Atlanta Tuberculosis Association. In 1935 Dr. M. A. Thomas, one of Atlanta's young colored physicians, completed an interneship at the Georgia State Tuberculosis Sanatorium. Dr. Thomas was taken on the medical staff of the Atlanta Association and he in turn organized a group of five of Atlanta's most progressive colored physicians into a service group. For six months Dr. Thomas conducted teaching clinics which included diagnostic and pneumothorax work. In February 1936 these five physicians in his classes were admitted into membership on the medical staff. Dr. Thomas, with the help of the Purves students and the nurses, gave tuberculin tests to 529 students in Booker T. Washington High School with the result that they found 41 per cent giving positive reactions.

As soon as the Washington High School study was completed the David T. Howard Junior High with something over 3,000 pupils requested that they have a group test during Negro Health Week. Miss B. E. Usher, the principal of the school, Prof. A. J. Lewis, director of health education, the school nurses and all of the teachers eagerly offered their assistance. Free tuberculin was secured through the courtesy of Dr. Esmond Long and the local association completed the demonstration which included tests on 616 children.

Dr. M. A. Thomas giving a tuberculin test to a student from Booker T. Washington High School, Atlanta, Georgia.

In order to make this testing as educational as possible, Prof. Lewis prepared the children by distributing literature and giving health talks in all classes. A moving picture film was furnished by the Georgia Tuberculosis Association and shown in the largest Negro theatre which would accommodate about seven hundred children at a time. One of the physicians appeared at each showing and explained that the film

* Executive Secretary, Atlanta (Ga.) Tuberculosis Association.

would demonstrate how and why the tuberculin test was being used.

After the children had returned from the theatre they came into the school clinic where the nurses and social workers prepared their record cards and the physicians administered the tuberculin. The details of this activity were directed by Mrs. Cecil Greenwood, supervising nurse of the Atlanta Tuberculosis Association. Since it was impossible to test the whole school the seventh grade group was selected and several suspicious children from the sixth and eighth were included.

The positive reactors in the group of 616 children were found to be 226 or 37 per cent. It was interesting to note that the reactions were as follows:

1 Plus—29 or 13%
2 Plus—95 or 42%
3 Plus—64 or 28%
4 Plus—38 or 17%

Each morning at 9:30 the nurses and clerical workers went into the school. The doctors came at ten and the tuberculin testing was completed each day by eleven. All negative reactors were given second strength. If for any reason a child was out of school the nurses went into his home in order to make the check up complete.

The Negro World, the Atlanta daily paper published by Negroes, gave daily publicity to the essay contests, to the testing demonstrations and to the general subject of tuberculosis. They published articles prepared by the doctors and students, and also news items.

The local association recognizes the fact that it now faces twelve months of intensive follow-up work. The clinic is X-raying and examining children, private doctors are stimulated in this field and already three children have been placed in the newly built children's ward that is the first to provide for colored children at our county sanatorium.

A Tuberculosis Poster Contest

by MARIE F. KIRWAN*

"Fight Tuberculosis with Modern Weapons" was the subject of the sixth state health poster contest carried on under the auspices of the New York State Departments of Health and Education and the State Committee on Tuberculosis and Public Health among high school students of the State outside of New York City. The contest closed May 20 with the judging of some 250 of the prize winning posters submitted from local contests. The judges of this contest, in addition to the outstanding health authorities of New York City who participated, included six leading art and advertising authorities.

Important prizes were a four-year scholarship in the Syracuse University College of Fine Arts and a one-year scholarship at the New York School of Fine and Applied Art, New York City. This is the fourth scholarship that Syracuse University has awarded.

These poster contests have had far-reaching consequences. In previous contests on the subject of diphtheria prevention the first prize winning posters were reproduced both in car card and 24-sheet billboard size. The Metropolitan Life Insurance Company reproduced one of the posters and distributed almost half a million of them throughout this country and Canada. The billboard posters were sold to local tuberculosis and health associations at cost, and to health authorities in practically every state in the United States and in many foreign countries including Canada, England, West Africa, and China. The posters were reproduced in miniature size for use in the "Health News" of the State Department of Health, in the "S.C.A.A. News" published by the State Charities Aid Association, and in numerous other publications and textbooks. The original posters are used throughout New York State by executive secretaries of local tuberculosis and health associations, at county fairs, and as window displays.

Art instructors and students look forward to participating in these contests and the art supervisor of the New York State Department of Education makes it the one state-wide poster contest that she authorizes in the high schools.

As an educational medium, the contest has proved of as much value. This year the following circulars were put into the hands of each art instructor for the use of students: "Nature Aids the Doctor"; "How the Sanatorium Pro-

* Contest Secretary and Secretary, Extension Service Committee on Tuberculosis and Public Health, S.C.A.A.

tects You"; "Splinting the Lung"; "Making the Cure Stick"; "On Your Guard"; and "Robber of the Prime of Life," prepared by the National Tuberculosis Association, and "Tuberculosis" and "Trudeau"—of the Health Hero Series of the Metropolitan Life Insurance Company.

Through newspaper publicity at the opening of the local contests and at the closing of the state-wide contest the general public is reached. Posters are placed on display in local schools thus calling the subject to the attention of other students. In addition, the executives of local tuberculosis and health associations arrange for talks before the various students.

The poster contest rules and regulations were prepared by the contest secretary with the advice of leading art and advertising authorities. A period of six months is usually allowed for the contest which closes with a local judging. This judging is made the occasion for considerable publicity by the local tuberculosis and health association which chooses local official and voluntary health authorities and art and advertising representatives to participate. At the close of the local contests, the first, second and third prize winning posters, as well as ten honorable mentions, are sent forward for state-wide judging.

For further details about the contest, or for a copy of the poster contest leaflet sent to students throughout the State, address: Mrs. Marie F. Kirwan, State Committee on Tuberculosis and Public Health, 105 East 22nd Street, New York.

Negro Case Finding in St. Louis

Definitely recognizing that the high incidence of disease among Negroes constituted a major obstacle in the ultimate control of tuberculosis, the Tuberculosis and Health Society of St. Louis, Missouri, launched an intensive case-finding survey among the city's 100,000 residents in April, 1936.

Development of the present survey was preceded by research into Negro tuberculosis control programs in operation in several major American cities and the conduct of extensive health education campaigns among Negro groups.

Beaumont district, which has a total population of 48,164 of which approximately 35,000 are Negroes, was selected for the original survey because of its consistently high Negro death rate over a period of many years. In 1934, the district had a death rate of 351 per 100,000 in contrast to the general Negro death rate of 224 and a white rate of 61.5. It may be observed that the Negro rate for this district more than doubles the national Negro death rate.

Using data obtained from the City Health Department and classifying residents according to race, income, living habits and cause of death, trained Negro investigators are making a house-to-house canvass of the district, taking case histories of all residents who have been ill during the past year.

Arrangements are made by the investigator for these persons to have a chest examination made, either by the family physician or by City Health Department physicians.

A unique educational project, in which health education is made available to Negro residents through their natural leaders, is being conducted in conjunction with the survey. Special programs of health education, which include talks, showing of the sound film "Contacts," and distribution of a special folder on tuberculosis for Negroes, which was prepared by the Society, are being scheduled for neighborhood groups.

A recent survey of tuberculous patients discharged from Robert Koch sanatorium disclosed that a substantially larger percentage of colored patients recover sooner and maintain good health longer than white patients, if given proper health education, diagnosis and treatment. The survey, it is hoped, will provide these three points of effective tuberculosis control.

Working Together for Youth

The Committee on Youth Problems of the U. S. Office of Education has just issued the first of a series of *Youth Bulletins*, entitled, "How Communities Can Help." Five million young people between 16 and 24 years of age—one out of every four in the country—are without constructive occupation. Some communities have developed coordinating councils representing the schools, the health departments, the character building agencies, churches, settlements, service clubs, and similar groups. California leads all the rest. Los Angeles County alone has 62 of these coordinating councils, and others can be found in a number of states.

"How Communities Can Help" gives some stimulating examples of the activities promoted by these groups in the fields of education, employment and recreation. An annotated bibliography completes this 77-page brochure. It is of compelling interest and significance, not alone for the guidance it gives in helping youth. "One of the most significant things that is happening" as the author points out, "is the cooperation which is being effected between the public agencies and the unofficial organization —a cooperation which is just in its initial stages and offers many possibilities."

Other bulletins to be issued by the Committee on Youth Problems of the U. S. Office of Education will deal with Leisure for Living, Education for Those Out of School, Vocational Guidance for Those Out of School, Employment Opportunities, Health Protection, and Surveys.

Health Education

How Behavior is Influenced

"The final test of health education is not how much information is distributed, but how behavior is influenced," writes Ira V. Hiscock in the June, 1936 number of the *American Journal of Public Health*. He emphasizes the need of careful planning of the health education program and suggests as a guide this 4-part question: (a) What ideas, images and emotional appeals must be conceived, accumulated, set forth and produced; (b) transmitted through what medium, or by what means; (c) to what audiences, in what locality or localities; (d) to accomplish what objectives?

"The technic of gaining public attention," says Professor Hiscock, is an art and a science, requiring a knowledge of human motivation, of human interests, and of human actions."

In Texas

The Texas Tuberculosis Association has a medical service committee consisting of eight tuberculosis specialists, two pediatricians and four general practitioners who have agreed to read papers on tuberculosis or to conduct symposiums on the subject at county medical societies. The doctors have offered to go to any medical society meeting within a radius of 100 miles of their respective homes, and at their own expense. Dr. H. F. Carman, president of the association, makes contact with the secretaries of each county medical society and offers them the service.

Tuberculosis Exhibit at Dallas

With the cooperation of the Negro Advisory Committee of the Texas Centennial Exposition an exhibit on Tuberculosis among Negroes has been developed by the National Tuberculosis Association. Funds for its construction were contributed in part by the United States Department of Commerce through an appropriation to the United States Public Health Service.

The exhibit consists of 12 units, each 3½ x 6 feet, covering 50 linear feet of wall space. Tuberculosis associations who are doing Negro work may find a use for it after it has done its job at Dallas.

The centerpiece is a life-size photograph of a husky Negro youth. His chest is transparent and as a flasher goes on the picture of a healthy and a diseased lung appears. The caption reads: "A healthy looking body may conceal tuberculosis." Above is a three foot circle with the double barred cross and the sentence: "Christmas Seals help fight tuberculosis."

To the left of the cross a photo-display panel depicts the forces that make for progress as clinic, sanatorium, public health nursing, school and church. To the right the obstacles are dramatized. "You are born without tuberculosis," the caption reads. Ignorance, futility, indifference, quackery and superstition are brought out in dialogue.

A FINE LOOKING BODY MAY CONCEAL TUBERCULOSIS
MODERN METHODS DISCOVER HIDDEN TUBERCULOSIS
THE X RAY LETS THE DOCTOR LOOK THROUGH YOU
THIS LUNG IS HEALTHY
THIS LUNG IS SICK

One of the twelve units

The statistical units are in the Isotype technic, in bas relief with cut-out superimposed symbols. The subjects are:

(1) Colored population has increased 41 per cent since 1910 but deaths from tuberculosis among colored people have decreased 54 per cent.

(2) There are now fewer deaths per 100,000 population among both the white and colored populations.

(3) and (4) One year's tuberculosis harvest among colored people in the United States.

(5) In the South, one-half of all deaths from tuberculosis are among colored people.

(6) Beds for tuberculosis in the 13 Southern states.

(7) Distribution of beds and deaths for each of the 13 states.

(8) How economic levels affect death rates.

The pathology of tuberculosis is presented by a unique device. A set of cut-out lungs in color that can be turned like the leaves of a book carry the story of how tuberculosis begins, develops and heals. This "lung book" is mounted on an over-life-size torso. The phrase "tuberculosis is still the leading cause of death between the ages of 15-45" is featured in large letters. Over the entire display

which covers 50 linear feet of wall space the following sentence is written in one foot letters: "Healing the sick is a duty—preventing illness is wisdom—protecting public health is statesmanship."

Statistics

Mortality in Foreign Countries

Almost every issue of the *Bulletin* of the International Union Against Tuberculosis presents tuberculosis and other statistics for one or more member countries of the Union. The October, 1935, issue of the *Bulletin* presents data for such an unusually large number of countries that it was felt a compilation of some of the figures would be of interest to our BULLETIN readers. These figures appear in the table below. For comparative purposes, figures for the United States have been added.

It is of interest to note that the tuberculosis mortality in six of the seven foreign countries for which rates are shown is two or more times the mortality in the United States, the Netherlands being the only one in which it is approximately the same as that for this country. It is of further interest to note the considerably higher mortality from the non-pulmonary forms of the disease in the foreign countries.

Particularly striking in this connection are the figures for the Netherlands where considerably more than one-fourth of the present mortality from all forms of tuberculosis is caused by non-pulmonary tuberculosis. This is about three times the United States mortality from non-pulmonary tuberculosis although the total mortality is approximately the same in the two countries. Mortality from the pulmonary form of the disease is, of course, correspondingly lower in the Netherlands.

Country	Year	Population	Mortality from all causes		Mortality from tuberculosis					
			Number of deaths	Death rate per 1,000 population	Number of deaths			Death rate per 100,000 population		
					All forms	Pulmonary	Other forms	All forms	Pulmonary	Other forms
Czechoslovakia	1932	14,726,158 (1930 census)	210,254	14.1	22,275	19,605	2,670	150	132	18
Netherlands	1931	7,998,568	77,048	9.6	5,811	4,159	1,652	72.7	53.0	20.4
	1932	8,115,817	73,043	9.0	5,227	3,668	1,559	64.5	45.2	19.3
Philippine Islands	1930	12,251,594	252,988	20.6*	33,931	31,945	1,986	277.0*	260.7*	16.2*
	1931	12,420,927	240,825	19.4*	33,849	31,987	1,862	272.5*	257.5*	15.0*
	1932	12,590,369	211,809	16.8*	31,681	29,925	1,756	251.6*	237.7*	13.9*
Poland	1930	—	490,370	15.6	59,573	55,305	4,268	189	176	13
	1931	32,132,936	494,893	15.5	64,044	60,128	3,916	200	188	12
	1932	32,176,000	487,125	15.0	—	—	—	—	—	—
Portugal	1932	6,984,461	118,895	17.0	11,685	9,647	2,038	170.2	138.1	29.2
Roumania	1933	18,550,000	400,000	21.7	34,000†	27,527	6,055	183.3*	149.4	32.9
Switzerland	1931	4,080,720	49,414	12.1	4,969	3,768	1,201	121	92	29
	1932	4,104,250	49,911	12.2	4,747	3,529	1,219	116	86	30
Uruguay	(Year not given)	1,903,083	19,825	—	2,586	2,195	391	—	—	—
Yugoslavia	1933	13,930,918 (1931 census)	261,478	—	—	36,463	—	—	—	—
United States	1932	120,122,200	1,308,529	10.9	75,509	67,789	7,720	62.9	56.4	6.5
	1933	125,693,000	1,342,106	10.7	74,842	67,422	7,420	59.5	53.6	5.9
	1934	126,425,000	1,396,903	11.0	71,609	64,706	6,903	56.6	51.2	5.4

* These rates computed in the office of the National Tuberculosis Association; other rates as published in the *Bulletin* of the International Union Against Tuberculosis.

† 34,000 is "official figure"—"more likely 45–50,000."

Source: *Bulletin* of the International Union Against Tuberculosis, October, 1935. (Except data for United States.)

School Health

International Congress on Open Air Schools

Miss Louise Strachan, of the National staff, will attend as an official delegate from the United States the Third International Congress on Open Air Schools to be held in Bielefeld and Hannover, Germany, July 18-23. Dr. I. W. Steele, Past Assistant Surgeon, U. S. Public Health Service, stationed at Berlin, will be the other official delegate of this country. Miss Strachan will report on the status of open air schools in this country.

In connection with the Congress there is to be an international exhibition on open air schools.

In Europe, as in this country, the open air school movement has resulted in better health provision for all school children. The Medical Officer of the Board of Education, London, England, recently reported that in at least 80% of the plans of elementary schools submitted to the Board for approval, classrooms are now provided which can be thrown open to the outside air.

For Schools in Rural Communities

The Buffalo (New York) Tuberculosis Association has recently issued an attractive photo-lithographed bulletin entitled, "Co-operative Activities for Healthful Living in Schools in Rural Communities." It describes how home, school, and community have worked together in Erie County, New York, for the health of the school children. One of the most interesting and stimulating features of the report is the part played by the school superintendents, principals, and trustees. The wholehearted support given by these administrators to the problems concerned with school health education is cause for congratulation to Erie County.

Lists of reference books for children and for teachers, and a questionnaire for teachers which points the way toward developing home, school, and community cooperation in health education, are appended.

Copies of the bulletin may be obtained from the Buffalo Tuberculosis Association, 708 Ellicott Street, Buffalo, New York, 15 cents each.

School Physicians Urge Tests for Teachers*

The following report of the Tuberculosis Committee of the American Association of School Physicians recently received makes another admirable "talking point" for tuberculin testing in schools of both teachers and students to follow Dr. Lees' fine presentation of "Tuberculosis Among Teachers" which appeared in last month's BULLETIN. The Committee agreed unanimously upon the following recommendations:

1. That the personnel, including teachers, engineers, clerks, and everyone coming in contact with children be adequately examined for tuberculosis; that this examination consist of: First, a tuberculin test and X-ray films of the chests of the positive reactors, and in lieu of the test for those who object to it, X-ray films be required. That all who show shadows suggestive of pulmonary tuberculosis have very careful clinical and laboratory examinations to determine whether the disease is progressive or whether tubercle bacilli are being eliminated through the sputum; that all members of personnel who have progressive tuberculosis or tubercle bacilli in the sputa be granted leaves of absence until their disease can be satisfactorily controlled and the sputum rendered negative for tubercle bacilli. That all employees negative to the tuberculin test be retested annually and those who refuse the test have X-ray films made annually. That every person seeking employment in a school system be adequately examined for tuberculosis.

2. That all children in the school system be adequately examined for tuberculosis; that this examination consist of the tuberculin test and X-ray films of positive reactors. Any child presenting shadows suggestive of reinfection type pulmonary tuberculosis be carefully examined by laboratory and clinical methods to determine whether the disease is progressive and whether tubercle bacilli are being eliminated by way of the sputum. That all children with progressive reinfection type of lesions, whether the sputum is positive or negative, have treatment instituted at once and all children with positive sputum be excluded from school until their lesions are brought under control and the sputum is negative. That all children who react negatively to the tuberculin test be retested at least annually and those whose reactions have become positive since the last examination have X-ray films of the chest. That in all cases where the tuberculin test is positive on first examination or on re-examination, an attempt be made to find the source of exposure in the homes or among other close associates.

The Committee is cognizant of the fact that the ideal program outlined above cannot be carried out completely in every school for various reasons, such as lack of sufficient funds and fanatical opposition. Under such situations, the Committee strongly recommends that a tuberculosis program be instituted even though it is necessary to begin in a very limited way. For example, when funds are limited it is suggested that the children of the first grade be tuberculin tested and followed by an attempt to find the source of infection in the homes and among the other close associates of all positive reactors; and that all high school seniors be tuberculin tested and X-ray films of the chest made of all positive reactors, since the reinfection type of chronic, pulmonary tuberculosis is much more prevalent among children of high school age than in children of earlier years.

* Report of meeting of Committee on Tuberculosis of the American Association of School Physicians, held in the Trudeau Memorial Room, Saranac Lake, New York, June 25, 1935.

The Committee's first choice of the testing material is Purified Protein Derivative in the two doses recommended by Long and Seibert. In the event that this material cannot be made available, that two doses of Koch's Old Tuberculin be used; the first to consist of 0.01 milligram of tuberculin (one-tenth cc. of a dilution of one part of tuberculin to 9,999 parts of normal salt solution). For those who react negatively a second dose of tuberculin, containing 1 milligram (one-tenth cc. of a dilution of one part of tuberculin to 99 parts of normal salt solution. In the event it is found impossible to administer two tests that a single dose, consisting of 0.1 milligram of tuberculin be used (one-tenth of a dilution of one part tuberculin to 999 parts normal salt solution).

The Committee strongly recommends that all of this work done by school physicians and others be carried out insofar as possible in close cooperation with the family physician in order to arouse or continue his interest in the tuberculosis control program of the country.

Enough work of this kind has been done in various parts of the United States to convince us that it is an extremely important part of the tuberculosis control program of the nation.

Signed W. P. Brown, M.D.
H. D. Lees, M.D.
E. R. Long, M.D.
W. J. Ryan, M.D.
J. A. Myers, M.D., *Chairman.*

Rehabilitation

As a continuation of the two short demonstrations of vocational counseling procedures carried on this past winter the National Tuberculosis Association has been able to send Mr. Harland Cisney to Saranac Lake for three months. The addition of such a worker was made possible through the kindness of Miss Whitney.

Mr. Cisney took the work for his Master's degree in psychology at the University of Minnesota. He has worked for a time in the Worcester State Hospital, and spent a week with Mrs. Burhoe and Miss Herz at Laurel Heights Sanatorium, Shelton, Connecticut, where 25 patients were put through the vocational guidance procedures. He is now part of the growing staff of the Saranac Lake Study and Craft Guild (see March Bulletin, page 40). The vocational counseling which Mr. Cisney is doing functions as an important factor in planning individual schedules of courses under the adult education program of the Guild.

Mrs. Burhoe has made a trip to Texas to aid in the establishment of a rehabilitation program there.

Demonstrations of the vocational counseling procedures continue to be made in sanatoria where the possibility of setting up a program is feasible.

Briefs from Current Periodicals

A Tuberculosis Survey in Papua

Papua, on the eastern end of the island of New Guinea, just across the straits from the northernmost part of Australia, lies south of the Equator. It is interesting from the point of view of tuberculosis since, for only about fifty years the natives of that island have been in contact with white people, who originally brought the disease there. Under the direction of the School of Public Health and Tropical Medicine of the University of Sydney, a careful survey of practically every inhabitant of the Village of Hanuabada, on the coast of Papua, was made in 1935.

Each of the 2,000 inhabitants of the village, which consists of about 250 houses built on stilts in the shallow part of the harbor, was given a careful physical examination and a tuberculin test. Sputum examinations were also included for all natives who gave a history of cough. Forty-three cases of tuberculosis were discovered, 21 males and 22 females, all of them showing active disease, about half being pulmonary. The case rate for the population was 21.5 per 1,000. In addition, a record of deaths from tuberculosis for two and a half years was kept and from these carefully kept figures, it was estimated that approximately 15 deaths occurred in the population per year or about 1/3 of the total number of deaths. This gives an unusually high death rate of 700 per 100,000. The tuberculin tests, given to 1,756 individuals, ranging from 0 to 50 or over years of age, showed that 61% of the group were infected. Among the children and young adults 78% gave a positive reaction.

In this paper published in the *Medical Journal of Australia* (Sydney, February 22, 1936), the author concludes that while the tuberculosis incidence is very high in this native village, it is not as high as among the South African natives as reported by Cummins and others, but is much higher than among the natives of Sudan, Tanganyika and Zanzibar.

Tuberculosis Among Negroes

In the January 1936 quarterly number of the *Bulletin of the International Union against Tuberculosis* is an unusually fine summary of the present status of knowledge with regard to tuberculosis among Negroes by Dr. E. Arnould of Paris. The article reviews the statistical, bacteriological and clinical concepts of tuberculosis as they have been observed chiefly among the following primitive peoples: the Senegalese during the world war, in the experience of Borrel with the Sudan natives;

the South African population; and more particularly among the Negroes of the United States. The differences in manifestation of tuberculosis in these groups are carefully studied and compared by the author. Raising the question as to whether the Negro organism by nature or by heredity develops characteristics toward the tubercle bacillus that are different from the white, the author concludes there is no scientific basis though this is the case. He quotes the experience of Opie to the effect that while tuberculosis lesions among Negroes in this country are much more rapid than those in whites, they usually do not show the same degree of malignancy observed among the Sudanese or Bantus.

In conclusion, the author summarizes his opinions as follows:

1. Negro groups in contact with white populations show a tuberculosis death rate three to five times as high as the whites.
2. The trend of the death rate, however, by sex and age is generally much the same as for the whites.
3. Social and environmental features seem to be largely responsible for the high death rate among Negroes.
4. The general clinical picture of tuberculosis is similar to that observed in tuberculous infants, a fact which contributes also to the high death rate.
5. The peculiar behavior of tuberculosis among Negroes is undoubtedly the result of features unfavorable to hereditary constitutional resistance. This is inferior to that in the whites and seems unable to protect the individual when he is submitted to living conditions to which he is not adapted.

Tuberculosis in Industry

Dr. P. Hefferman, formerly tuberculosis officer of the Derbyshire County Council in England, writing on the subject of "Industrialism and Tuberculosis" in the March, 1936, issue of *Tubercle*, summarizes British experience with this problem in two paragraphs, which we quote verbatim:

> It would now appear to be well established that, apart from certain notoriously unhealthy occupations, such as those of potmen, barmaids, and street prostitutes, the only industries with a specific risk of tuberculosis are those in which the inhalation of certain mineral dusts consisting mainly of uncombined silica is a constant condition. An attempt has been made recently to show that cowmen in dairies have a high rate of incidence for tuberculosis, but the evidence is scanty, and nothing useful can be said about it. As regards the influence of industrialism generally on human tuberculosis, our medical knowledge of pre-industrial Britain is too meagre to enable us to draw reliable conclusions. We know that at the present time people of rural and remote pastoral and agricultural communities or districts in this country may have a very low tuberculosis death-rate. On the other hand, they may have a very high tuberculosis death-rate, as in certain of the Welsh valleys; and show little resistance to the disease when freshly introduced.
>
> While we all deplore the hideousness and squalor of the industrial slum, we are well aware that some of our picturesque rural villages are appalling from a sanitary and health point of view, and that C3 people are found in both. On balance, there seems to be little doubt that the high standard of living which the industrial age rendered possible has contributed materially to the reduction in tuberculosis. When, however, certain industries fall upon evil days, as has happened in our depressed areas, the standard of living and the nutrition of the people dependent on these industries is likely to fall below that of a pastoral or rural population, and the result is soon apparent in the rise in the tuberculosis incidence and death-rates which follows.

Bovine Tuberculosis in Man

In answer to the question, how much human tuberculosis is of bovine origin, there is an excellent summary of a study on "The Incidence of the Bovine Bacillus in Lesions Found in Man" in the February, 1936, number of the *Canadian Public Health Journal*. The study is by Dr. M. H. Brown of Connaught Laboratories and School of Hygiene, University of Toronto.

Dr. Brown studied 241 strains of tubercle bacilli isolated from a wide variety of lesions in man including sputum, urine, spinal and pleural fluids, pus from various areas and cervical glands. He found that 233 or 96.68 per cent of the strains studied were of the human type and only 8 or 3.32 per cent were of the bovine type. The highest incidence of bovine type occurred in strains isolated from the spinal fluid, 10.2 per cent being of this variety. In not a single instance was the bovine type isolated from material taken from the lungs or respiratory tract.

News Reel

The American Public Health Association will hold its sixty-fifth annual meeting in New Orleans October 20 to 23. Dr. Thomas A. Parran, Jr., Surgeon General of the United States Public Health Service is president-elect of the association.

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Iowa shows an increase in deaths from tuberculosis in 1935, for the first time in ten years. There were 660 deaths and a rate of 26.5 per 100,000 population in 1935.

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Miss Fannie B. Shaw of the National staff will participate in the meetings of the Department of School Health and Physical Education of the National Education Association during the week of June 28 to July 2 when the annual conference of the National Education Association takes place in Portland, Oregon. She will lead a panel discus-

sion on "Trends and New Materials in Secondary School Health and Physical Education." The program for the Department has been arranged by Dr. Edna W. Bailey of the University of California.

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The *Ipswich Tribune* of Ipswich, Edmunds County, South Dakota, contributed to the seal sale by printing a two-column box on its front page and pasting a seal in the box.

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Boston College announces the opening of a School of Social Work September 14, 1936. The school will be open to college graduates and will offer a two-year course leading to a master's degree.

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The United States Public Health Service has appointed a committee of eight health officers to constitute an advisory board which will aid in formulating a standard public health code as a suggestion for the various states. The personnel of the advisory committee is as follows: W. F. Walker, Dr. P.H., Commonwealth Fund, New York; H. F. Vaughan, Dr. P.H., City Health Commissioner, Detroit, Mich.; Hugh R. Leavell, M.D., City Health Officer, Louisville, Ky.; A. D. Weston, Chief Sanitary Engineer, State Health Department, Boston, Mass.; H. A. Whittaker, Chief Sanitary Engineer, State Health Department, Minneapolis, Minn.; J. N. Baker, M.D., State Health Officer, Montgomery, Ala.; Earle G. Brown, M.D., State Health Officer, Topeka, Kan.; and George C. Ruhland, M.D., Health Commissioner, District of Columbia.

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"The Health Officer" is the title of the new mimeographed Bulletin recently issued by the U. S. Public Health Service, Office of Public Health Education, Washington, D. C., dealing with the newer developments in the public health field in various states and as they relate particularly to the work of the health officers. Vol. I, No. 1, is the May 1936 issue.

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Two attractive annual reports have recently been received from the Delaware Anti-Tuberculosis Society and the Tuberculosis League of Pittsburgh. Although entirely different, both are unique in typographical layout and general content with good pictures.

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In a little over six months, from October 1935, more than 37,000 persons saw the motion picture "Contacts."

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The final issue of the Child Health Bulletin, Volume XI, Numbers 5 and 6, under date of September-November 1935, has recently come from the press and is "The Story of the American Child Health Association." Dr. Philip Van Ingen, its author, has continuously served as secretary of the organization, since its founding in 1923, and before that was actively associated with the American Association for the Study and Prevention of Infant Mortality. This later became the American Child Hygiene Association, which united with the Child Health Organization of America to form the American Child Health Association. Dr. Van Ingen reviews in detail the work of these two parent organizations and their successor and pays tribute to the devoted efforts of those who have been intimately associated with the work since its beginnings in 1908. Included are 7 pages of annotated child health literature.

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A board of judges of the United States Chamber of Commerce has announced the winners of the seventh city health conservation contest conducted annually by the Chamber of Commerce in cooperation with the American Public Health Association. The contest is supported by a group of insurance companies. In 1935 there were 234 cities in the contest whose populations totaled over twenty-three millions, more than one quarter of the total urban population of the country, forty-five states, the islands of Hawaii, and Alaska.

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"Big Little Things in Conquering Pulmonary Tuberculosis" by Dr. Samuel H. Watson, is an attractive, 16 page booklet for the patient. It answers in simple language the questions so commonly asked by the patient beginning the cure. The tone is optimistic and helpful. Dr. Watson generously offers to supply copies of the booklet for six cents to cover the cost of mailing. Write to Dr. Samuel H. Watson, #2 Paseo Redondo, Tucson, Arizona.

The Discussion Method of Conference

The New York and New Jersey Conferences of Social Work have experimented with the development of the discussion method as compared with the usual set papers. We suggest this method is admirably adapted to certain types of state and other annual meetings.

In New Jersey, the groups were limited to thirty people, each discussing the same subject and coming together at three general sessions with speakers of outstanding ability on three phases of the subject. Each discussion leader was given a course of training for several months preceding the conference, in order to be able to cooperate more intelligently in the discussion.

Information concerning the use of this plan may be found in a bulletin issued by the Association of State Conference Secretaries, Mrs. Mary B. Holsinger, President, Drawer 17, State Office Building, Albany, New York.

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